Form v1.0
Rev.06/01/2006

STATE LOGO

Draft Hurricane Morbidity Report Form
For Active Surveillance in Clinical Care Settings

▶ Complete one form per patient. Use category or categories that best describe the reason the patient is **currently** seeking care.

Part I VISIT INFORMATION

1. LOCATION & NAME OF FACILITY:
2-letter STATE _____ NAME OF FACILITY / STATION

2. DATE OF VISIT:
MM DD YYYY

3. TIME OF VISIT:
: 24-hour Clock

Part II PATIENT INFORMATION

4. MEDICAL RECORD NUMBER (If available):

5. DATE OF BIRTH:
MM DD YYYY

6. AGE (YEARS):
O < 1 year

7. RACE/ETHNICITY (Check all that apply):
O White O Black/African American O Hispanic or Latino O Asian O Other

8. SEX:
O Male O Female

9. ***If Female***, PREGNANT?
O Yes O No O Unknown

Part III REASON FOR VISIT

▶ Please check **all** categories related to patient's **current** reason for seeking care. Specify 'Other' as appropriate.

INJURY

- O **Bite / sting**, *specify:*
  - O dog
  - O insect
  - O snake
- O **Burn**, *specify:*
  - O chemical
  - O fire, hot object or substance
- O **Cut / struck by or against**, *specify:*
  - O debris
  - O machinery/tools/equipment/chainsaw
- O **Drowning / submersion**
- O **Electrocution**
- O **Fall**, *specify:*
  - O from one level to another (e.g., down stairs; from ladder, building, or tree)
  - O on same level
- O **Foreign body** (e.g., in eye, splinter)
- O **Motor vehicle traffic**, *specify:*
  - O driver / occupant
  - O pedestrian / bicyclist
- O **Overexertion** (from): lifting, pulling, pushing, or excessive activity (e.g., muscle or joint pain, back strain, fatigue)
- O **Poisoning**, *specify:*
  - O CO exposure—from generator
  - O CO exposure—from other source
  - O inhalation of other fumes, dust, or gas
  - O ingestion of poison
- O **Violence / assault**, *specify:*
  - O sexual assault
  - O other assault
  - O suicide / self-inflicted injury
- O **Undetermined**
- O **Other**, *specify:* _____

ACUTE ILLNESS / SYMPTOMS

- O **Acute neurological symptoms** (e.g., altered mental status)
- O **Cold-related illness** (e.g., hypothermia)
- O **Conjunctivitis / eye irritation**
- O **Fever** (i.e., >100.4° F or 38° C)
- O **Gastrointestinal illness**, *specify:*
  - O watery diarrhea
  - O bloody diarrhea
  - O nausea / vomiting
- O **Heat-related illness or dehydration**
- O **Jaundice**
- O **Meningitis / encephalitis, suspected**
- O **Pain**, *specify:*
  - O chest pain or angina
  - O headache or migraine
  - O muscle or joint
  - O oral / dental
- O **Respiratory illness**, *specify:*
  - O cough, *specify:*
    - O dry O productive O with blood
  - O sore throat
  - O shortness of breath or difficulty breathing
  - O wheezing in chest
  - O lower respiratory infection, suspected
- O **Skin / soft tissue**, *specify:*
  - O generalized rash (e.g., chickenpox)
  - O localized rash (e.g., dermatitis, eczema)
  - O skin, soft tissue, or wound infection
- O **Syncope**
- O **Other**, *specify:* _____

ROUTINE / FOLLOW-UP CARE

- O Medication refill
- O Other, *specify:* _____

EXACERBATION OF CHRONIC ILLNESS

- O **Cardiovascular disease**, *specify:*
  - O hypertension
  - O coronary heart disease (e.g., MI)
  - O congestive heart failure
- O **Cerebrovascular disease / stroke**
- O **Chronic pain / arthritis**
- O **Diabetes**
- O **Respiratory disease**, *specify:*
  - O asthma
  - O COPD
- O **Other**, *specify:* _____

MENTAL HEALTH

- O Agitated or frantic behavior
- O Disoriented to person, place, or time
- O Drug/alcohol intoxication or withdrawal
- O Seeing/hearing things that aren't there
- O Suicidal thoughts or attempt
- O Unable to care for self or dependents
- O Violent behavior / threatening violence
- O Other, *specify:* _____

OBSTETRICS / GYNECOLOGY

- O **Routine pregnancy check-up**
- O **Complication of pregnancy** (e.g., bleeding, abdominal pain, fluid leakage)
- O **In labor** with/without complications
- O **Premature birth complications** affecting mother or infant
- O **GYN condition** not associated with pregnancy or post-partum period
- O **Other**, *specify:* _____

Part IV RELIEF WORKER / RESPONDER INFO

10. RELIEF WORKER / RESPONDER:
O Yes O No O Unknown

11. JOB TITLE AT THIS INCIDENT:

12. DID INJURY/ILLNESS DEVELOP WHILE WORKING JOB SPECIFIED IN **Q11**?
O Yes O No O Unknown O Not Applicable

Part V DISPOSITION

- O Discharge to self-care
- O Died
- O Admit / refer to hospital
- O Unknown
- O Refer to other care (e.g. clinic, physician, center)
- O Left before being seen